Neurologic Surveillance and Testing

through the Viral and Rickettsial Disease Laboratory at the California Department of Public Health

Physicians MUST obtain approval from NST before sending samples.
Fax this form to 916-440-5940 or email to NeuroSurveillance@cdph.ca.gov to obtain approval.

Patient Information

Last Name_____ **First Name** _____ **DOB** ____/____/____ **MR #**_____

Street Address _____ **City** _____ **Zip Code** _____ **County** _____

Tel (_____)_____ **Name of surrogate decision-maker or guardian** _____

Race: □ White □ Black □ Asian/Pacific Islander □ Other □ Unknown **Ethnicity:** □ Hispanic □ Non-Hispanic

Gender: □ Female □ Male **Occupation** _____

Exposure Information (within 1 month of onset)

Animal or Arthopod contact □ No □ Yes Details: _____

Immunization in last month □ No □ Yes Details: _____

Medications (including OTC and herbal): □ No □ Yes Details: _____

Outdoor activity (camping, hiking, gardening, etc): □ No □ Yes Details: _____

Other pertinent exposures (including day care, head trauma, sick contacts, TB exposure etc)_____

_____

Travel 1 month before onset? Specify dates and locations

□ outside U.S. _____ □ in U.S. _____ □ in CA _____

□ Ever traveled outside the U.S.? _____

Significant Past History

Immunocompromised? □ No □ Yes If yes, please elaborate: _____

Hypertension □ No □ Yes Diabetes □ No □ Yes (If yes, what type? Insulin dependent?) _____

Other PMH (medical, social, family)_____

Clinical Information

Illness onset date ____/____/____ Date of hospital admission ____/____/____ Fatal? □ No □ Yes

Discharge date ____/____/____ Discharge location_____ If fatal, date of death ____/____/____

Glascow Coma Scale (1-15) _____

In ICU □ No □ Yes Date: ____/____/_____

Intubated □ No □ Yes Date: ____/____/_____

Fever ≥ 38^0 □ No □ Yes _____

URI □ No □ Yes _____

GI □ No □ Yes _____

Rash □ No □ Yes _____

Severe headache □ No □ Yes _____

Lethargy □ No □ Yes _____

Confusion □ No □ Yes _____

Aphasia or mutism □ No □ Yes _____

Extreme irritability □ No □ Yes _____

Hallucinations □ No □ Yes _____

Psychosis □ No □ Yes _____

Stiff neck □ No □ Yes _____

Ataxia □ No □ Yes _____

Focal neurologic □ No □ Yes _____

Muscle weakness □ No □ Yes _____

Cranial nerve abn □ No □ Yes _____

Seizures □ No □ Yes _____

Intractable? □ No □ Yes

Induced coma? □ No □ Yes Date: ____/____/_____

Coma □ No □ Yes Date: ____/____/_____

Autonomic Instability □ No □ Yes _____

Movement Disorder □ No □ Yes _____

Abnormal Reflexes □ No □ Yes _____

Hypersalivation □ No □ Yes _____

Laboratory Results

CSF Results

Date ____/____/____ OP_____ RBC_____ WBC_____ Diff ___/___/___/___ Protein _____ Glucose _____ VDRL _____
seg/lymph/mono/eos

Date ____/____/____ OP_____ RBC_____ WBC_____ Diff ___/___/___/___ Protein _____ Glucose _____ VDRL _____
seg/lymph/mono/eos

Was HSV PCR on CSF performed at hospital/commercial lab? ☐ No ☐ Yes *Result*: ☐ NEG ☐POS

CBC Results

Date ____/____/____ WBC_____ Diff ____/____/____/____ HCT _____ Hb_____ Platelets _____ Glucose _____
seg/ lymph/ mono/ eos

Date ____/____/____ WBC_____ Diff ____/____/____/____ HCT _____ Hb_____ Platelets _____ Glucose _____
seg/ lymph/ mono /eos

LFT ☐ Normal ☐ Abnormal _____ **ANA** ☐ Normal ☐ Abnormal _____

BUN/Cr ☐ Normal ☐ Abnormal _____ **CXR** ☐ Normal ☐ Abnormal _____

ESR ☐ Normal ☐ Abnormal _____ **Oligo bands** ☐ Normal ☐ Abnormal _____

Other labs, cultures, microbiological studies, Xrays, test results: _____

_____

Brain CT Date ____/____/____
☐ Normal ☐ Abnormal ☐ Not done
If abn: ☐ temporal lobe
☐ white matter demyelination
☐ hydrocephalus
☐ severe cerebral edema
☐ other_____

_____

Brain MRI Date ____/____/____
☐ Normal ☐ Abnormal ☐ Not done
If abn: ☐ temporal lobe
☐ white matter demyelination
☐ hydrocephalus
☐ severe cerebral edema
☐ other_____

_____

EEG Date ____/____/____
☐ Normal ☐ Abnormal ☐ Not done
If abn: ☐ diffuse slowing
☐ temporal epileptiform activity
☐ PLEDS
☐ other_____

_____

_____

Treatment

Antiviral agents _____ Date Started ____/____/____

Antibacterial agents_____ Date Started ____/____/____

Steroids? ☐ No ☐ Yes _____ Date Started ____/____/____ **IVIG?** ☐ No ☐ Yes Date Started ____/____/____

Physician/Hospital Contacts ****** REQUIRED – FOR RESULTS & FOLLOW-UP******

Treating Physician Name _____ Pager (_____)_____ Email _____

Primary Physician Name _____ Pager (_____)_____ Email _____

FACILITY _____

FAX (for sending results) (_____)_____ Alternative FAX (_____)_____

REQUIRED STEPS FOR SUBMITTING SAMPLES:

1. Physicians must obtain approval from NST **prior to** submission of samples. See instructions or website http://www.cdph.ca.gov/programs/vrdl/Pages/NeurologicSurveillanceTesting.aspx for more information.
2. Send ALL required samples (CSF, acute serum, NP/Th swab) with Case History Form and Specimen Submittal Form to: Attn: Specimen Receiving, 850 Marina Bay Parkway, Richmond, CA 94804
3. Notify your local public health department of all cases submitted for testing.

Specimens will not be tested unless all 3 requirements have been met. Call 510-307-8608 with questions about NST.